Requisition Form

miR Scientific®
Transforming Cancer Management ™

miR Sentinel™
PROSTATE CANCER TEST

685 Route 1 S, Ste 110
North Brunswick, NJ 08902
mirsentinel.com

855-55-CALLMIR (855) 552-2556
Secure Fax No. (800) 305-0489
Secure Email trfs@mirsentinel.com

Place miR-supplied barcode here
Place other barcode with patient name and DOB on Urine Collection Cup

PATIENT INFORMATION

*Indicates required information

Patient's First Name*	MI	Patient's Last Name*	Date of Birth (**mm-dd-yyyy**)*	Biological Sex*
Patient's Street Address*	Suite, Apt #	City/Town*	State/Province*	
Postal Code*	Country	Patient's Phone*	Patient's Email	

ORDERING PROVIDER'S INFORMATION

Provider's First Name*	MI	Provider's Last Name*	Account Name*
Account Address*	Suite, Apt #	City/Town*	State*	Postal Code*	Country (*Required if outside the US)
Account Phone*	Ext.	Account Fax or Email*	

PATIENT SAMPLE INFO

*Sample Type: At least **30mL of voided urine** collected at least 1 full hour after last urination. Sample should not be collected in the 72 hours after performing a DRE.*

Collection Date: (**mm-dd-yyyy**)* | Time* AM ☐ PM ☐

ICD10 Code(s)*

Has Patient had a previous miR Sentinel™ Prostate Cancer Test Yes ☐ No ☐

Provider confirms that the Fax or Email is HIPAA Compliant* Yes ☐ No ☐

PROVIDER ATTESTATION

By signing below, I, the undersigned (or my duly authorized representative), represent that I am a licensed health professional authorized to order this test. The patient has been informed of the risks, benefits and limitations of this test, as well as the implications of the results, and has been given an opportunity to ask questions and discuss concerns about this test. I confirm that the patient is greater than 45 years old, testing meets the stated indication of suspicion or risk for prostate cancer and that testing is medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome, or disorder for the patient. I further attest that I have obtained from the patient all consents and authorizations required by and in compliance with applicable state and federal laws for the performance and billing of the testing being ordered.

I attest that the patient has been informed of the following:

1. If the test is billed to the patient's health insurer or plan, miR Scientific, LLC may share the information on this form and the test results with the patient's plan on the patient's behalf. and the benefits will be made payable to miR Scientific, LLC.

2. Patient may be responsible for amounts not paid by the plan directly to miR Scientific, LLC for the test ordered including cost-sharing obligations. Patient has been provided with, or informed how to obtain, a good faith estimate.

3. This test may not be covered by the patient's plan. If it is outside of the plan's coverage guidelines or deemed not medically necessary (e.g. - where prior authorization is required but not obtained) the patient may be responsible for the cost of the test.

Provider NPI*

Provider Signature* | Date (**mm-dd-yyyy**)*

PATIENT INSURANCE/BILLING INFORMATION

Please fill in required information below or attach a copy of patient's insurance card.

Bill to* Insurance ☐ Medicare ☐ Patient (Self-Pay) ☐ Other:

Name of Insured Person* | Name of Insurance Company*

Patient Relationship to Insured* Self ☐ Spouse ☐ Other:

Policy Number* | Group Name/Number

Return completed Test Requisition to:

Fax: (800) 305-0489

Email: trfs@mirsentinel.com

Mail: miR Scientific, LLC, P.O. Box 23072, New York, NY 10087

FOR miR LAB USE ONLY

miR Lab:
Place accession barcode here

FOR miR LAB USE ONLY
Sample Received
Date: (mm-dd-yyyy)*

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miR SENTINEL™ PROSTATE CANCER TEST:
OPTIONAL PATIENT CONSENT TO USE SAMPLE FOR RESEARCH

I permit my de-identified sample and information resulting from its analysis to be stored by miR Scientific or its designee for as long as deemed useful, which may be indefinitely, and used by miR Scientific, its affiliates and research partners for future research and development purposes:
Initial here: YES _____ NO _____

I permit researchers at miR Scientific to contact me or my provider in the future for an update on my status, or to discuss potential research studies or other health related products or services which may be appropriate for me:
Initial here: YES _____ NO _____

Patient signature/patient's authorized representative's signature: _____ Date_____

If authorized representative, please provide the relationship to patient _____

PATIENT MEDICAL INFORMATION (if applicable)

Patient Medical History of Prostate Cancer? Yes ☐ No ☐

Most Recent Biopsy: Date

Most Recent PSA: Date (**mm-dd-yyyy**)

Most Recent PSA: Result

Most Recent Biopsy: Result
T1c ☐ T2a ☐ T2b ☐ T2c ☐ Neg ☐ Other ☐

PATIENT ETHNICITY & RACE (optional)

Is the patient of Hispanic or Latino origin or descent?

Yes ☐ No ☐

Please mark one or more that apply:

White ☐
Black or African-American ☐
Asian ☐
Native Hawaiian or Other Pacific Islander ☐
Other:_____ ☐
American Indian or Alaska Native ☐